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Introduction

Offhand references to the notion of the 'Nordic model' abound both within and without welfare research. As we will see in this paper, there certainly is something to this idea of the Nordic model, but at the same time it can be blinding to important intra-Nordic diversities in terms of social policies and social policy change. This working paper will go in-depth with intra-Nordic diversities at the policy level in three select policy fields. The main focus will be on the changes of the most recent 25 years, but we will also take a broader historical look on the different pathways to relatively universal policy schemes. To put the 'Nordic model' or 'welfare regime' in its European context, we will also briefly discuss the literature taking up the discussion of whether the Nordic countries really have distinctly universal welfare states.

The three policy fields selected for this paper are pensions, health care and unemployment protection. These represent three main corners of the welfare state. Two of them, pensions and unemployment protection, concern income transfers, where transformative changes have taken place to different degrees in the Nordic countries. The last policy field, health care, concerns services rather than transfers, and has not experienced as radical changes from the perspective of universalism, even if significant reforms of the public sector and to some extent the public/private mix in service provision has been seen. As such, the three policy fields represent very well some main trends that we will review below before going in-depth with these specific policies.

The notion that the Nordic countries represent something very distinct in terms of welfare and social development is nothing new. The idea of the Nordic 'model' became something of a brand for these countries some decades after World War II (Petersen 2011). International interest has billowed back and forth since then. Arguably, this interest has picked up again in most recent years, perhaps with the realization that the idea of the very comprehensive and universal Nordic welfare states needs a service check. The special feature of the Economist (2013) on the Nordic 'supermodel' is a good example since the Nordic countries in this feature are lauded for reforming their welfare states and making them less generous or universal.

Within comparative welfare research, investigations into welfare regimes firmly established the notion of a distinct Nordic welfare regime as epitomized by Esping-Andersens (1990) *The Three Worlds of Welfare of Welfare Capitalism,* yet efforts into welfare typologizing that included a Nordic or Scandinavian model can be traced back to Richard Titmuss (1974) and even earlier still (Powell & Barrientos 2011). Since then, there has been a long and exhaustive discussion regarding if and how the Nordic countries are distinct or how they have changed (Dølvik et. al. 2014; Kananen 2014; Kvist et. al. 2012; Hvinden & Johansson 2007; Kangas & Palme 2005;

Kautto et. al. 2001). Arguably, it easier to identify this 'Nordicness' on a range of social outcomes such as social trust (or other aspects of social cohesion), low poverty, low material deprivation and relatively low economic inequality, while the Nordic cases are often more diverse on the policy level. We could say that diverse policies (with some common denominators) have achieved very similar social outcomes. Yet, updated accounts of basic policy changes across both several Nordic country cases and policy fields at the same time are very difficult to come by. It is this lack in much of the most recent literature that we seek to make up for here.

The Nordic model: Relatively universal or not?

Generally, recent empirical enquiries continue to find support for a distinct Nordic world of welfare (Vis & Van Kersbergen 2014). The meta-review of Arts & Gelissens (2010), for example, includes 11 studies, of which the three Scandinavian countries of Denmark, Norway and Sweden always cluster together, while Finland only ends up in the Nordic cluster with the three other countries in five of the studies. In some respects, Finland resembles an archetypal Continental-European or conservative welfare regime, and later we will see how Finland across all three policy areas included here looks like a universal/conservative hybrid.

Naturally, findings across these studies differ according to whether the focus is on welfare regimes or more narrowly limited to welfare state policies and according to the indicators investigated. Consequently, the very general picture painted above of the continued existence of the Nordic *sui generis* can be nuanced a good deal if we focus solely on the policy level and differentiate between policy areas. Already at the turn of the millennium Kautto et. al. (2001) noted that various strands of literature now distinguished between at least five models of social insurance, five care models, four family policy models, for models of gender policy and three models of unemployment protection. This complexity can be reduced somewhat if we distinguish between the two main areas, namely services and income transfers.

In the world of income transfers, comparative research has increasingly had difficulties identifying distinct differences that correspond to the classic threefold welfare regime distinction. The update and replication of de-commodification scores by Scruggs & Allen (2006) is a case in point. Across the three benefits in question (pensions, unemployment insurance and sickness) the results were somewhat ambiguous. For each benefit, it is possible to identify several countries with scores similar to or even higher than the Nordic cases. However, across all three benefit types (and thereby closer to the regime level), the three Scandinavian countries generally had the highest scores alongside the Netherlands, Belgium and Switzerland. The three small Continental-European countries are often grouped alongside or close to the Nordic countries in the empirical welfare regime literature (Arts & Gelissen 2010).

Over time, the trend for many European countries Nordic and non-Nordic alike has been that income protection for the unemployed has become less generous and coverage has decreased (Ferragina et. al. 2013; Clasen & Clegg 2011). While there are significant a difference between the Nordic countries, unemployment protection has in general become less generous and less distinct compared to non-Nordic Europe (Kuivalainen & Nelson 2012; Hussain et. al. 2012). The Nordic benefit systems have become less efficient at combating relative poverty, although social minima in terms of benefit levels are often still relatively high (Hussain et. al. 2012). We will take a closer look at the dynamics behind these changes in the sections below.

As regards welfare services, a classic critique of the early research into typologies was that services simply where 'the forgotten half' of the welfare state (Jensen 2011). At the same time, this is arguably where the Nordic countries were (and continue to be) most distinct. For example (and even though expenditure data do reveal much about qualitative difference in principles behind social policy in different countries) the Nordic countries have long spent relatively much on service areas such as health, education and care policies (ibid.). To some extent, much of Continental Europe has been catching up with Nordic Europe in this regard. The biggest differences are found in care and family policies and this is also where the Nordic countries are most unique. If we focus on family policies, however, there has been a marked tendency towards expansion of the role of the welfare state across most of Europe (Ferragina et. al. 2013). However, this should not necessarily be interpreted as welfare regime convergence in family and care policy. The policy expansion in continental Europe has often has taken place in ways that emphasize existing regime differences, for example via the extension of comprehensive cash-for-care schemes (Stoy 2014).

We can try to summarize this discussion of Nordic vs. non-Nordic Europe. As regards services on the one hand, particularly family policy, we may in some instances speak of welfare state expansion in continental Europe. Still, these are the policy areas where the Nordic countries are most distinct, and welfare state expansion may happen in regime-dependent ways. On the other hand, income transfers, particularly unemployment protection, constitute an area where the Nordic countries seem to have converged towards the rest of Europe.

The embryonic Nordic welfare states

The history of the emerging Nordic welfare states began in the 1890s when all the Nordic countries introduced their first national social insurance laws. Sequencing, time spans and the level of economic development varied quite substantially between the countries. Denmark had the highest degree of industrialization and introduced first old age relief, then sickness insurance, work accident insurance and unemployment insurance in quick succession from 1891 to 1907. Sweden and Norway had not introduced national policies in all of these areas until the mid-1930s. In the case of Sweden, it was because the country waited until 1934 to

adopt an unemployment insurance scheme, while Norway introduced national old age pensions in 1936. Finland was much less industrialized than the three Scandinavian countries, and introduced sickness insurance as the last of the four forms of insurance in 1963. The late emergence of national pension and sickness benefits in Finland are some of the main examples of how Finland has often been described as a laggard or Nordic 'latecomer' in terms of welfare state development (Kangas & Saloniemi 2013).

Table 1: The first Nordic social insurance laws

	1st social insurance law			2nd social insurance law			3rd social insurance law			4th social insurance law		
	Law[1]	Year	SD[2]	Law	Year	SD	Law	Year	SD	Law	Year	SD
Denmark	PI	1891	50	SI	1892	50	WA	1898	52	UI	1907	55
Finland	WA	1895	22	UI	1917	27	PI	1937	37	SI	1963	62
Norway	WA	1894	40	UI	1906	45	SI	1909	46	PI	1936	50
Sweden	SI	1891	47	WA	1901	50	PI	1913	55	UI	1934	61

Source: Kangas & Palme (2005); Esping-Andersen & Korpi (1986).

1) Law: SI = Sickness insurance; PI = Pension insurance; UI = Unemployment insurance; WA = Workers accident.

2) SD = Rough reading of "socio-economic development" from Kangas & Palme (2005). The index is noted as based on "industrialization and laborization" but it is not explained any further.

Insurance schemes were of course to be found in the Nordic countries before the introduction of national legislation. For example, some municipalities introduced the first public pension schemes for municipal workers, and various insurance schemes had emerged long before national legislation as voluntary, non-public schemes arranged by guilds, trade unions or employers. We will return to this in the various policy-specific sections below.

It should be noted that beyond these first national social insurance schemes, various 'poor laws' were introduced much earlier in all the Nordic countries, yet they should of course not be likened with social assistance in the modern sense since penalization, stigmatization and loss of civil rights were very much features of the early poor laws (Esping-Andersen & Korpi 1986). Denmark introduced its first poor law in 1803, while the other three Nordic countries adopted their counterparts in 1845-1852. In terms of social assistance-laws, Denmark was once again the early mover in 1933, while the rest of the Nordics enacted their first laws in 1956-1965. Denmark was also a European latecomer, however, since the last element of loss of civil rights related to public support was not dismantled until 1961 (punitive loss of voting rights in some special cases).

Pensions: Nordic paths to universalism

With their early pension schemes from 1889 and 1891, respectively, Germany and Denmark are commonly seen as the founding fathers of two very fundamental and different branches of both pension and welfare models (Ebbinghaus & Gronwald 2011; Palme 1990). Germany set off on the so-called 'Bismarckian' path, and adopted a mandatory and contributory system based on the principle of status maintenance or income replacement, divided according to different status groups, while Denmark took to the 'Beveridge' path (as it came to be known after World War II) based on citizenship (Ebbinghaus & Gronwald 2011). The Danish 1891-scheme was not at all universal but rather residual in the way that it was strictly means-tested and partly was an attempt to remove the elderly from the existing poor law and extend proper old age support. Despite the residual nature of the scheme, the citizenship principle enshrined in the scheme and the aim of combating poverty makes it easier than a Bismarckian scheme to convert to fully fledged universalism, something that also illustrates a form of kinship between the universal and residual welfare regimes (Beland et. al. 2014).

Sweden in 1913 adopted its first national pension reform. Here, a basic pension was ensured for all retirees in the way that it combined fully funded, contributory pensions with means-tested supplements. For this reason, it has been argued that it was the first piece of social legislation based on universalism (Anttonen & Sipilä 2012; Esping-Andersen & Korpi 1986). A contributory system was discussed in Denmark at the same time, but by the time a commission handed in its report in 1914, the Danish centre-left, which opposed the idea, had gained the majority. Norway in 1936 adopted its first national pension scheme, which was similar to the Danish system because it was tax-financed and means-tested, while Finland in 1937 set out on an initially more 'Bismarckian' path with a fully-fledged compulsory and defined-contribution based pension scheme for all workers (Kangas & Luna 2012; Kuhnle 1987). The Finnish scheme, however, also included a means-tested supplement and was more in line with the Swedish system (Kautto 2012).

The various schemes all evolved into universal old-age pensions in different ways, but the timing was similar. Sweden turned its basic pension into a PAYG-system without any means test in 1948 with the same flat-rate benefit for all pensioners (Lindquist 2011). Denmark and Norway adopted universal basic pensions reforms in 1956 and 1957, respectively (Goul Andersen 2011a; Kuhnle 1987). Finland also made a switch from its more Bismarckian path to a completely universal and flat-rate benefit in 1956 (Kangas & Luna 2011). Originally, the reform agreed between the Social Democrats and the Agrarians did preserve the principle of status-

maintenance through income-related pensions for those in employment, but that was abandoned by the Agrarians in the final vote (Kangas & Luna 2011).

The switch towards universalization did not happen as abruptly as the impression might be from the above. The early, non-universal pension Nordic pension schemes all had their incremental steps towards the citizenship-principle enshrined in universalism. In 1922, Denmark adopted fixed rather than discretionary entitlements, a further step away from early poor relief (Petersen 2006). Benefit levels were not uniform or national, however, since there were different scales for different parts of the country, and some pensioners, particularly singles, experienced lower benefits following national legislation. In 1918, Sweden restricted the possibility of occupational groups who already had their own occupational schemes to opt out of the national scheme, and all groups including government employees were included in the system from 1937. At the same time, the pension became more tax-financed (Lindquist 2011). Finland also expanded coverage of its public scheme, for example by including the disabled (Kautto 2012).

Towards multitiered pension systems

The next step and critical juncture in pension evolution, not only specific to Nordic countries, is whether an adequate earnings-related pillar is added to the pension system to maintain incomes within the context of the economic development of the post-World War II period (Ebbinghaus & Gronwald 2011).

Outside the public pension system, the earliest occupational pension schemes came into existence in the Nordic countries already before the 20th century. The very earliest non-public pensions in the private sector were not sector-wide agreements, but a result of unilateral decisions by employers. More occupational and sector-wide agreements followed around the same time as the era of the first public reforms covered above, but coverage remained low. Public sector employees usually had high coverage, while things were quite different in the private sector, particularly among blue-collar workers (Goul Andersen 2011a; Lindquist 2011; Kangas & Luna 2011). In Finland, for example, only about 20% of the workforce was covered by occupational pensions towards the end of the 1950s. In other words, there seemed to be a need for a statutory solution to ensure adequate pensions for all wage earners.

The Nordic countries diverged somewhat on this issue, particularly in the case of Denmark, where policymakers failed to introduce an adequate earnings-related tier, which partly led to the crowding-in of non-public pension solutions (Kangas et. al. 2010). In Denmark it only to a limited degree happened as ‘pressure from below’, since the final push towards crowding-in

happened when government and municipalities agreed together on expanding labor market pensions, as will be explained below.

In Sweden, discussions began already in the 1940s about complementing the public basic pension with a more adequate solution for wage earners since the existing occupational pensions only covered most segments of the labor market to a very limited degree. In 1960, Sweden adopted a defined benefit or earnings-related PAYG-based supplementary pension, the ATP (Lindquist 2011). Norway adopted a similar scheme, which also bore the name ATP, in 1967. Already in 1960 such a scheme was agreed through collective bargaining, but it became legislated seven years later (Esping-Andersen & Korpi 1986). 1967 was also the year when Norway finally adopted its long-discussed National Insurance scheme, which integrated various universal-coverages insurance schemes, increasing old-age pensions (Kuhnle 1987)

In Finland, a different sort of agreement of was reached in 1961 with a coalition outside the government (once again, the Agrarians in the government were against an earnings-related tier). This made employment-related pensions statutory and compulsory within the private sector (Kangas & Luna 2011). Public sector employees had had their own funds for nearly a century, but were later homogenized into two new funds in 1964, one for municipal employees and another for state employees. Farmers and self-employed were included in the statutory provisions in 1974, but also with their own two pension funds. In this way, the Finnish ATP-equivalent became one marked by sectoral divides. This made the Bismarckian legacy in Finland clear once again, as did arguably the fact that the earnings-related pensions had no formal ceiling (unlike the Swedish and Norwegian ATP-schemes) (Kangas et. al. 2010).

The story is wholly different in Denmark, where no adequate earnings-related pension scheme was added to the public pension system. A new and fully funded pension benefit which bore the ATP-name was adopted in 1964. The benefit was based not on previous income, however, but on the number of contribution years with contributions being fixed. (Petersen & Petersen 2012) The scheme was partly a compensation for a government intervention in collective negotiations and a crisis package (Goul Andersen 2011a). Furthermore, the Danish labor movement was divided on the issue, and the fact that the Danish basic pension was more generous than elsewhere also hampered the advocacy of an adequate ATP-solution. This meant that the Danish public pension system in terms of replacement rates was more generous for low work incomes relative to the other Nordic counterparts, but somewhat less generous for average work incomes and markedly so for high incomes (Ploug & Kvist 1994). The addition of a truly earnings-related supplement was heavily debated in the second half of the 1960s but never adopted.

The fact that the Danish ATP was so limited (and not earnings-related) meant that it did by itself not make a very significant difference for most pensioners. This contributed to the later crowd-in of occupational labor market pensions. The number of cross-sector pension funds increased rapidly. By 1986, for example, 34% of white collar workers in the private sector and 48% of their counterparts in the public sector had such pensions (Goul Andersen 2011a). A mandatory system, which would perhaps have been not entirely unlike the Finnish, was suggested by the Danish federation of trade unions, but the right-wing government and employers disagreed. A corporative commission on pensions was appointed in 1988, and one year later government and municipalities together expanded labor market pensions to all municipal workers who did not already have one. This was the watershed, and it set the pace the subsequent expansion in the private sector.

This is a contrast to the Finnish case, where the public pension system without any benefit ceiling can be argued to have effectively hampered the development of private or collectively negotiated solutions (Kangas & Luna 2011). In Finland, occupational pensions outside the compulsory pensions only cover around 20% of the labor force and individual, private pensions about 15% (Kangas & Saloniemi 2013). On the other hand, Kangas & Luna (2011) also acknowledge that the Finnish system is situated in a gray area between public and private, since it has enshrined the sectorally divided and privately run occupational and earnings-related pensions as statutory and compulsory. In the Danish case, Goul-Andersen (2011) argues that the Danish labor market pensions constitute a quasi-universal solution, even if they were not adopted through legislation, because of the way they have been institutionalized in collective labor market agreements. This illustrates the blurry boundaries in Nordic multipillar pension systems. However, when we speak of 'near universal coverage' because of collective agreements and the fact that labor market pensions have also become standard for work places outside agreements, we should remember that there are those who spend a significant share of their working life outside the labor force. In 2008, 78% of the Danish labor force were included in labor market pensions (Goul Andersen 2011a).

Non-public labor market pensions through collective agreements did certainly also emerge as significant pillars within the pension system in Sweden. In Sweden, for example, collectively agreed labor markets pensions also have near-universal coverage, but contributions are low[1] because public pensions are much more adequate (and contributions towards public pensions

[1] The contribution rates for the four major collectively negotiated pension funds (two for public and two for private employees) are all of them at 4.5% of the wage (Lindquist 2011). An exception is found in the two private sector schemes, where wage amounts above a level of 7.5 times the so-called base amount has a contribution rate of 30% (the base amount was 51.100 SEK in 2010), a level which corresponds roughly to the average Swedish wage according to Eurostat (2013). Nevertheless, this still makes for a very low total contribution rate for most workers. In Denmark, by contrast, contributions vary between 12 and 18% of wages (Goul Andersen 2011).

very significant). In Norway, the system was until recently overwhelmingly based on the public, PAYG pension system. For this reason, pension savings were also quite low compared to the other countries. In 2011, pension savings were equivalent to 7% of GDP in Norway (according to OECD-estimates), while it was 64% and 84% in Sweden and Finland respectively (Goul Andersen & Hatland 2014). In Denmark it was an extreme 187%. Such massive pension savings can be found nowhere else in the world.

Today, the Nordic pension systems have all emerged as multitiered pension systems, although the degree to which this equals evolved multipillar systems varies. As we shall see below, this has happened alongside very significant reforms of a primary concern from a social citizenship perspective, namely the basic and universal public pensions. Universalism as a policy principle in its most strict sense can no longer be found in Finland, Norway or Sweden. Here, the basic pensions are now completely negative-selective (income-tested), while Denmark has maintained universalism, but also increased the degree of positive selectivism (income-tested supplements) significantly.

In Sweden, political discussions about the long-term sustainability of the pension system began already in the 1980s (Berglund & Esser 2013; Lindquist 2011). In 1994, a committee with members from all parliamentary parties agreed on a report to overhaul the pension system, but prolonged political negotiations meant that the final reform was not decided until 1998. The first tier of the public pension system was changed from a universal pension to a so-called 'guarantee pension', a completely negative-selective pension benefit designed to benefit those with inadequate benefits and savings from other pension schemes (except the premium pension explained below). The guarantee pension is not means-tested against private pensions whether occupational or individual in order to induce private savings. The second, earnings-related tier, now dubbed 'income pension', was changed to a notional defined contribution (NDC) pension scheme. The NDC system is predominantly PAYG-based, but mimics a funded DC-system in the sense that contributions are linked to 'notional' accounts which are used to calculate benefits adjusted by life expectancy at retirement. On top of this is the 'premium pension', which is funded and DC-based. The contribution rates are 16% for the NDC-scheme and 2.5% for the premium pension. This also illustrates why contributions for occupational pensions are much lower in Sweden than in Denmark, since contributions towards public, earnings-related pensions are so high. Retirement is flexible between 61-67 years, with income from the NDC-system spread out over the remaining (expected – by gender and age cohort) lifetime to induce late retirement.

Effective from 2011, Norway reformed its pension system along some of the same lines as Sweden, with political deliberations taking place in 2001-2009. Norway also adopted a

negative-selective guarantee pension as the first tier. An important difference is that the benefit level of the Norwegian income pension, the second tier, is not DC-based. Instead, each individual will increase their pension income entitlements by 18.1% of annual income, which is adjusted each year by wage growth to secure real adequacy (Goul-Andersen & Hatland 2014; Hippe & Berge 2013). There is no public 'premium pension' as in Sweden either. On the other hand, it has since 2006 been mandatory for employers to adopt occupational, defined contribution plans with a minimum contribution of at least 2%, which is quite similar to the Swedish premium pension. As in Sweden, retirement is flexible with incentives to retire late, but in this case the span is 62-75 years.

In Finland, reforms of the earnings-related pensions were less radical. However, Finland abolished the universal basic amount of the national pension, whereby the pension became entirely income-tested, already in 1995 (Kautto 2012). This followed a series of const-containment measures a few years before (which continued into the new millennium) (Kangas & Saloniemi 2013; Kangas & Luna 2011; Kangas et. al. 2010). Measures included weakening the indexation of benefits and lengthening the calculation period of pensionable wage from the last four to the last ten years of employment. Pension contributions were also shifted towards employees. In 2002-2005, the various private and public sector funds were subject to a series of reforms which abolished the target level of 60% replacement rate. Later retirement was incentivized by letting pension accrual rates increase with age and the adjustment of pensions by a life expectancy coefficient. However, the reforms also increased coverage somewhat by including more welfare benefits in accrual calculations (Kautto 2012).

In 2011, Finland also added a 'guarantee pension' to ensure a higher minimum at the lower end of the income scale. This guarantee pension is income-tested against both the basic national pension and earnings-related pensions. Early 2014 saw another reform decision (effective from 2017), the most important element of which is a gradual increase of pension age for birth cohorts born after 1995 (currently it is flexible around 63-68 years) (Finnish Centre for Pensions 2014)

While Denmark has not seen a complete removal of pension universalism as a policy principle, the national pension has certainly shifted towards being more income-tested than before. From 1994, the amount of the universal benefit became roughly equal to its means-tested supplements, and in 2003 another means-tested supplement was added. Furthermore, the basic pension has since 1984 been means-tested against income from employment (Goul Andersen 2011a).

The shift away from universalism as a policy principle in the basic national pensions in Finland, Norway and Sweden is not as radical when seen through the perspective of benefit levels. For example, Kautto (2012:155) notes on the shift away from the universalism in 1995 in Finland that it was radical in principle, but that it was not *"…really revolutionary in practice, as pension recipients still got more or less the same amount of pension".* The cost containment measures in preceding years (briefly noted above) had a much larger impact on benefits. Similarly, Blomqvist & Palme (2014:10) notes that in Sweden: *"….the basic, flat-rate level of pension benefits guaranteed in the 1998-system is slightly higher than in the old system".* The various national minimum pensions achieve replacement rates which are in the end not that different for people with no contributory pensions, these being (in 2007) 56% in Denmark, 52% in Norway, and 46% in Sweden, but also a significantly lower 38% in Finland (Nososco 2009). However, we should bear in mind that these numbers are before the introduction of the new guarantee pensions in Norway and Finland (in Finland it is significantly higher than the old minimum as explained above).

In conclusion, there has certainly been a shift towards multitiered pension systems in all the Nordic countries, but by different degrees and different paths. In terms of pension pillars, occupational, non-public pensions in Denmark (and Finland, if we consider the privately managed but compulsory occupational pensions) dominate the pension system much more than in Sweden and particularly Norway. These new and generally more DC-based schemes are by nature better adjusted towards changes in life expectancy (and then various political decisions such as life expectancy coefficients or increasing pension accrual rates by age also help in that regard). More inequality among future pensioners would logically be expected since earnings-related pensions will matter much more for future pensioners since these new institutional shifts are still maturing. On the other hand, it is not necessarily a given fact, since statutory (or quasi-statutory in Denmark) earnings-related pensions and more selective basic pensions with high minima might complement each other well. In Denmark, for example, inequality is expected to decrease among pensioners and to be lower than among the population in general (Goul Andersen 2011a).

The shift towards multitiered pensions has happened in quite different ways in the Nordic countries. However, whether it has happened within or without legislation does not always make an equally big difference in the end. All Nordic countries have broadly shifted in various ways to much more DC-based pension systems. These pensions have universal coverage for employees because of their compulsory nature, except for Denmark, where the institutionalization of labor market funds through collective agreements exclude a small minority of workers. Of course, in all the Nordic countries there is an issue for citizens who have had a weak connection to the labor market during working age. These people are much more

reliant on the by now more selective national minimum pensions, whether positive-selective (as in Denmark) or negative-selective (as in Finland, Norway and Sweden), but these all have relatively high minima.

Unemployment insurance: Nordic rise and Norwegian demise of the Ghent model

As shown in table 1, Norway and Denmark were the first Nordic countries to adopt national legislation on unemployment insurance in 1906 and 1907, respectively. Finland followed in 1917, and this time Sweden was the laggard until it also adopted such a scheme in 1934. The Nordic countries all followed the so-called 'Ghent model', named after the Belgian city of Ghent in which it was first implemented in 1901, whereby the state subsidized voluntary insurance in unemployment funds connected to labor unions. France, however, was the first country to establish the principle at the national level in 1905 (Vandaele 2006). The Ghent system has survived only in Denmark, Finland and Sweden. Belgium has retained a form of quasi-Ghent model, where the government also plays an important part in distributing benefits (ibid.

Similar political forces were behind the first legislation in Denmark, Finland and Norway, where voluntary state-subsidized insurance managed by unions could reconcile conflicting interests of both agrarian parties and the Social Democrats. Edling (2006) emphasizes that one reason behind the much later legislation in Sweden was that the country did not yet have universal suffrage. The much more powerful estate owners and farmers in Sweden blocked attempts at similar legislation. Some skepticism also dominated unions in Sweden, however, and as in Norway and Finland they also thought that public subsidies were too low. Not unlike the previous experiences in the other Nordic countries, union funds were slow to register and in 1940 only 11% of employees were in funds registered and subsidized by the state. No until 1941, when state contributions increased significantly, among other things, did coverage begin to pick up speed (Berglund & Esser 2013; Edling 2006).

When Norway first adopted the Ghent model, it seemed to be the right compromise in a situation where public solutions for unemployment benefits was increasingly needed, but where the perception also was that the state might not be able to take this on (Caroll 2005). The state simply built on the existing framework of union funds by simply subsidizing benefits. This framework was much more developed in Denmark, where unions around 1910 organized around 50% of the new industrial working class against 12% in Norway and 5% in Finland. Fund membership was also several timers higher in Denmark (Edling 2006).

Funds themselves still decided their own entitlement criteria and benefit levels also varied. Funds could distinguish between groups according to for example gender, income or contribution periods as they saw fit. This autonomy regarding entitlements and what constituted involuntary unemployment was later contested in Norway, especially from the right wing parties, in cases where funds granted benefits to workers who had quit their jobs voluntarily if employers cut wages or did not raise wages. It could appear as if the state supported union causes such as higher wages (Caroll 2005). In all three countries, however, it was established that workers could not receive benefits during strikes (Edling 2006).

In the infancy of the Nordic Ghent systems, state subsidies were more generous in Denmark than in Norway and Finland, where subsidies were defined as a share of benefit expenses, rather than tied to members' contributions as in Denmark (Edling 2006). On the other hand, the Danish set-up was more regressive, since it favored funds with low unemployment. In Norway, the union themselves opposed the 1906-reform in the first few years because state subsidies at one quarter of expenses were deemed too low and not sufficient compensation for the loss of autonomy (such as the requirement to open up for unorganized workers or separating strike funds from benefit funds).

Such continuous conflicts coupled with the worsened economic situation in the 1920s after World War I contributed to the demise of the Ghent model in Norway in 1938. Union membership rates bloomed to 27% in 1920 following an increase in maximum benefits and duration period, but then dropped sharply again in the following years (Edling 2006). Norwegian unions had furthermore failed in boosting fund membership, and up until 1935 only a quarter of union members were enrolled in the funds (Carroll 2005). It seemed like the existing set-up was simply unable to cope with increasing unemployment. Coverage was too low, and the funds struggled with finances for those that were covered. Listening to sceptics that were also vocal within the unions, the Social Democratic government switched sides on the merits of voluntary insurance and finally abolished the system in order to replace it with compulsory insurance in 1938. The compulsory scheme increased insurance coverage tenfold, and was articulated as a triumph for the labor movement.

Unemployment insurance in Finland faced many of the same problems, and on top of this came the domestic political turmoil inherited from the civil war in 1918. Only about 10% of workers were unionized by 1935, even lower than the 21% in Norway at the time, and as in Norway fund members were a clear minority (Edling 2006). Unions were continually accused of harboring revolutionary ambitions by the political right. Indeed, the far left continued to have strong influence after the civil war, and the Finnish Confederation of Trade Unions (SAJ), founded in 1907, was outlawed in 1930 after a Communist takeover (Carroll 2005). Its

successor, SAK, was led by Social Democrats, but nonetheless its leaders were often jailed on oftentimes fabricated charges of state treason. In 1931 and 1934, laws were enacted to protect the 'industrial peace' which among other things prohibied any links between funds and other organizations if they could throw into doubt the independence of the funds. This lead to the suspension of eight funds (out of 10) (Edling 2006; Carroll 2005). Yet, Finland kept its commitment to the Ghent model despite a high degree of domestic political conflict and a Ghent model that evolved very slowly in the beginning. In contrast to Norway, the Finnish Social Democrats kept defending the system.

Retrenchment of unemployment insurance

After the adaption of Nordic Ghent models and the varying degrees of turmoil surrounding them (which lead to complete abandonment of the Ghent system in Norway), the schemes all became much more generous and encompassing in the post-World War II years. Norway incorporated agricultural workers and a few other leftover occupational groups into its compulsory unemployment insurance in 1949, thereby making it universal (Kuhnle 1987). In 1971, the scheme was incorporated into the National Insurance Scheme along with health insurance and work injury, marking the transition to a fully integrated system of various universal-coverage insurance schemes.

For the other Ghent-based systems, the road towards towards universalization of voluntary insurance was a bit windier. One important step towards universalization in Denmark was the reform of state contributions to funds in 1958, which tied state contributions to expenses rather than income (Jørgensen 2007). This means that state contributions were increased and contribution levels greatly equalized across funds. This alleviated inequalities across funds greatly. Sweden also increased the level of financing in 1952 (Edling 2006). The final step in terms of financing is completely severing the link between unemployment levels and member contributions, which makes contributions uniform and fixed. In Denmark, this happened in 1967-1970 as the state fully overtook the 'marginal risk of unemployment' (Goul Andersen 2012). At the same time, the benefit ceiling was doubled in 1967, and the replacement rate jumped from 35% to 70% of an average wage (Jørgensen 2007). The reforms in 1967-1970 laid the institutional foundations for the modern setup of the benefit. The corresponding overhaul of unemployment insurance in Sweden happened in 1973 (SO 2006). In Finland, the foundations for the current unemployment insurance were laid with a reform in 1985 (Lilja & Savaja 1999).

These reforms also meant that member contributions became relatively negligible in the Nordic Ghent systems, at least until the 1990's. Member contributions had shrunk to about to an estimated 5% of expenditures in Sweden and 20% in Denmark (Torp 1999). Contributions were more complicated in Finland, but the scheme also retained quite low member financing around 5-10% in most of the 1990's (Lilja & Savaja 1999). In all three countries, employers also paid significant contributions, particularly in Finland (Lila & Savaja 1999; Torp 1999). From 1997, employer contributions were abolished in Denmark, however. Since then, there has been a trend towards increasing member contributions in all countries. In Sweden it has been most abrupt and radical, which we will return to below.

In terms of generosity of the Nordic unemployment insurance schemes, a distinction can be made between the Finnish scheme on the other hand, which does not have a benefit ceiling, and the three Scandinavian benefit schemes, where benefit ceilings are in place (AK Samvirke 2012; Torp 1999). Benefit ceilings in the Scandinavian countries has the effect that benefits de facto become flat-rate for much of the workforce (Clasen et. al. 2001). This means that the Finnish scheme is much more earnings-related, but from a lower baseline, which means that only for working incomes above 150% of the average wage is the Finnish scheme significantly more generous in terms of replacement levels[2] (OECD 2014a).

Benefit levels have been subject to some retrenchment, most significantly in Sweden. Firstly, Sweden like Denmark used to have a formal replacement rate of 90% below the ceiling, but this was lowered to 80% in 1993, and in 2007 this was reduced further to 70% and 65% for the unemployed after 200 and 300 days of unemployment, respectively (Goul Andersen 2012; Sjöberg 2011). Furthermore, Sweden removed automatic adjustment of the benefit ceiling in 1993 and it has only been adjusted upwards two times since then (by late 2014, the new Social Democratic-led government has proposed to raise the ceiling significantly, however). This development has gradually turned the Swedish benefit into a flat-rate scheme for more than 80% of the insured unemployed (Berglund & Esser 2013; Sjöberg 2011) The benefit ceiling was previously relatively high in Sweden, but the combined effect of these benefit retrenchments has been a drop in net replacement rates for an average wage from 87% to 60% (ibid). This is one factor behind the expansion of private unemployment insurance in Sweden, which has become a standard item in collective agreements between employers and employees. In 2012, more than 53% of union workers or 37% of the labor force had private unemployment

[2] At these high income levels, the Nordic schemes vary around 42-49% replacement rate, except for Sweden at 34% (in 2012). At the lower rungs of the income scale with a working income at 67% of the average wage, Denmark is significantly more generous with a replacement rate of 84%, while the other Nordics schemes have replacement rates of 59-68%. The relative Danish generosity for low incomes is the result of a high formal replacement rate of 90% of previous income below the ceiling, while it is 80% in Sweden and 62.4% in Norway

insurance, which typically tries to raise total benefits to the 80% replacement rate-level (Rasmussen 2014).

The Swedish retrenchment of the early 1990s was partly caused by a difficult economic recession at the time where unemployment rose from 2% to 8%. The situation was even worse in Finland, where declining benefit generosity was most evident following a big economic crisis in 1991-1994, where GDP dropped by 14% and unemployment rose from 3% to 18% (Heikkinen & Kuusterä 2001). Following the crisis of the early 1990s, price indexation of the base level of unemployment insurance was suspended until 2002 (Ervasti 2002). In 1992, the earnings-related part of the benefit was also reduced, but this has later been raised back to the original benefit formula[3] (Lila & Savaja 1999). As GDP and wages resumed normal growth (and Finland even entered a small economic boom), the level of unemployment benefits lagged greatly behind wage incomes (Lehtonen et. al. 2001). Unlike the other two Nordic Ghent countries, however, benefit levels have also been raised significantly in the new millennium. The earnings-related part of the benefit formula was raised markedly in 2003 during the first 20-200 days of unemployment depending on the degree to which certain criteria regarding previous employment can be fulfilled[4] (Uusitalo & Verho 2010). Furthermore, in 2005, a special 'transition allowance' was enacted, which raises the benefit level even higher during participation in certain activation measures (Ministry of Employment and the Economy 2012)[5]. The benefit 'floor' or the base level of the benefit formula was raised markedly in 2012[6] (ibid.).

Denmark did not to the same extent experience very noticeable cutbacks in benefit levels, yet the benefit ceiling has declined somewhat over time relative to wages because the indexation mechanism adopted in 1990 entails that benefits are not raised at the same rate as wages during times of high economic growth. This development has gradually turned the Danish benefit into a de facto flat-rate benefit for almost all workers (Goul Andersen 2011b). Replacement rates have dropped 10-15% since then for most workers, while a recent tax reform, which among other things reduces indexation of benefits in 2016-2023, will push net replacement rates further down by around 4%. In Norway, the single most important change to the benefit ceiling happened in 1989, when the ceiling (above which any additional income is disregarded for benefit calculations) was halved from twelve to six times the 'base amount',

[3] The earnings-related part of the formula is that 45% of income above the benefit base level is replaced up to a certain point (close to the average wage), while 20% of income above this point is replaced.
[4] Rates for the earnings-related part of the benefit formula are raised to 57.5% and 35%, respectively, during initial employment if: 1) Previous employment lasted more than three years (raised benefit for 20 days), 2) Previous employment lasted more than 20 years and fund membership at least five years (raised benefit for 100 days).
[5] The transition allowance further raises the benefit rates explained in the footnotes above to 65% and 37.5%
[6] The raise was 120 EUR, equaling a 22% raise of the benefit floor.

which was one big step towards making the benefit both less generous and less dependent of previous income (Clasen et. al. 2001).

Coverage of the contemporary Nordic unemployment insurance schemes has been relatively high, except for Finland. In the early 1990s, 70%-75% of the unemployed were covered in Denmark, Norway and Sweden, while it hovered around 50% in Finland (Torp 1999; Lila & Savaja 1999). The reason why coverage of the compulsory Norwegian scheme is not 100% is that duration is of course not unlimited while a work qualification criterion has to be fulfilled as elsewhere[7]. Coverage has since then declined somewhat, most noticeably in Sweden, where a steep decline from 2005 and onwards has placed coverage below 30% of the unemployed (Berglund & Esser 2013; Sjöberg 2011). The trend is so far less evident in Denmark and Finland. However, the long-term effect of lower benefit duration in Denmark is yet to be seen, and the case of Finland we should remember that coverage was already lower to begin with. The lower coverage of unemployment insurance (and greater reliance on social assistance) in Finland is one reason why means-tested social expenditure has traditionally made up a larger share of total social expenditure than in the other Nordic countries (Hvinden et. al. 2001)

In Denmark, the move towards less generous coverage began by the middle of the 1990s, partly due to shortening of the benefit duration period in successive reforms. Maximum duration before 1993 was in reality up to nine years, but a 1993-reform capped duration at seven years. This was then lowered to five years in 1995, four years in 1998 and two years in 2010 (effective from 2012) (Goul Andersen 2012, 2011b). However, these very significant cut in benefit duration over several years has not had as dramatic an impact on coverage of the unemployed as one would perhaps expect (Goul Andersen 2011b). Coverage has been relatively stable due to the fact that the duration cuts of the 1990s happened in a context of falling unemployment. The recent changes (from four to two years coupled with a doubling of the re-qualification criteria) should have more significant long-term impacts.

In Norway, the tightening of unemployment benefits was not as marked as in the other Nordic countries (Halvorsen 2002). Duration was actually extended in 1984 from 40 weeks (repeatable after 12 weeks without benefits) to 80 weeks (repeatable after 26 weeks without benefits (Halvorsen & Jensen 2004; Clasen et. al. 2001). In 1997, the no-benefit period was abolished and duration differentiated according income, so that incomes at more than twice the 'base amount' could receive benefits for 156 weeks and those below that income level had the right to 78 weeks. While this meant that work history now played a role for benefit duration, it was a

[7] Duration is two years (one year for very low incomes). Qualification criterion is 1 year of wage income within the last year (or within the last three years for high incomes). Sick or maternity leave also count as wage income.

marked extension of duration for the great majority of wage earners. Later, duration was shortened to the present 104 weeks and 52 weeks, respectively.

Sweden and Finland have not witnessed the Norwegian fluctuations or the Danish cuts in benefit duration, but here duration was already considerably lower than in Denmark. Sweden has retained its benefit duration of 60 weeks and Finland its own of 100 weeks.
Denmark, Sweden and Finland have all either abolished or shortened special duration extensions for elderly unemployed, however. In all three countries, benefit duration could be in practice nearly unlimited before the 1990s since participation in various active labor market measures counted as 'work' when fulfilling the work requirements. In Denmark, only subsidized employment via the 'job offer' scheme counted besides ordinary employment, but a cap on the number of public job offers (two) was set in 1990, and the 1993-reform meant that subsidized employment could no longer be included in the work criterion. In Sweden, by contrast, participation in a broad range of ALMP measures could be included in the work criterion (since 1986), and it was not abolished until 2001. However, Sweden at the same time installed an 'activity guarantee', renamed 'job and development guarantee' in 2007, during which one receives a lower gross replacement rate of 65% after the ordinary unemployment benefit has been exhausted (Berglund & Esser 2013; Sjöberg 2011). Duration of this 'guarantee' on lower benefits is in principle limited to 90 weeks, and the guarantee is divided into various faced during which one participates in different ALMP-measures. If no job is found after 90 weeks, one has the right to be placed with an employer. Finland has not completely removed ALMP-measures from the work criterion, and half of the hours worked in a publicly subsidized job are counted as work (AK Samvirke 2012).

The work requirements themselves are of course also important for coverage of unemployment insurance. All the Nordic countries have in various ways limited coverage in this way. Norway is a bit special in this regard, since the work criterion has always been defined by minimum income level, making it more of an income criterion than a work criterion. In 1989, this was raised from an income of 0.75 to 1.25 times the 'base amount' within the last year (Clasen et. al. 2001). This barred very low incomes such as students or elderly women in seasonal work from the benefit (as would probably also be the case if a work criterion had been in place). This has later been raised to 1.5 times the base amount (which is still very low). In Denmark, the work requirement was doubled from 26 weeks to 52 weeks of employment within the last three years in 1995, and the aforementioned2010-reform also doubled the requalification requirement to 52 weeks (from 2012). This makes the Danish work criteria by far the most restrictive among the Nordic Ghent systems, since the work criteria in both Sweden and Finland are less than a full year, and furthermore, a 'work week' is equivalent to full-time employment

in Denmark, but not In Sweden and Finland (ibid.)[8]. However, it should also be noted that the Danish work requirements can be fulfilled three years, while it is one year in the two other countries. In Finland, the work requirement was raised from 26 to 43 weeks of part time employment in 1997, but the requirement could be fulfilled within the previous 24 months rather than the 8 months before (Lilja & Savaja 1999). This was later reduced to the present 34 weeks within 48 weeks. In Sweden, work requirements were also strengthened, but the period during which the requirement could be fulfilled was also extended, and the consequences for coverage were relatively marginal (Sjöberg 2011)[9]. Other factors, such as restricting access for students as new entrants into the labor market, had a larger impact.

In Sweden, a 2007-reform which sharply increased and differentiated member contributions, causing members to opt out of funds, was a more important factor behind declining coverage. Member contributions were tripled and state contributions somewhat disconnected from 'the marginal risk of unemployment', which meant that membership contributions increased the most in funds with high unemployment (Berglund & Esser 2013; Sjöberg 2011). This differentiation was further increased in 2008, and about half a million members left the funds in 2007-2008 (Goul Andersen 2012). The difference in contributions between funds had increased from 4 EUR/month to 41 EUR/month in 2012 (IAF 2013). Overall, member contributions soared to constitute 59% of benefits in 2008, up from 12% in 2007 (ibid). The government tried to offset this with a small decrease in contributions in 2009, which brought the figure down to just below 40%. Denmark has also seen an increase in member financing, but there it has not been as abrupt, and more importantly, differentiation between funds has not been adopted. Member contributions were openly raised in the 1980s, and less visibly so by a 1998 reform which separated contributions to early retirement from contributions towards unemployment insurance. Because of very low unemployment, the Danish government actually profited from member contributions in 2008 (in other words, member financing was above 100% (Goul Andersen 2012). Another hidden measure, which has been utilized in both Sweden and Denmark, is lowering or abolishing tax deductions on contributions. In Denmark, contributions had been fully tax deductible, but the value of deductions was reduced to 33% in 1998 and 25% in 2009 as elements of larger tax reforms (ibid.). The Social Democratic-led government raised it again from 2015, however. The tax deduction had been 40% in Sweden, but it was abolished completely with the 2007-reform.

[8] Denmark: 52 weeks at 37 hours = 1924 hours (within three years). Finland: 34 weeks at 18 hours = 612 hours (within 48 weeks). Sweden = 26 weeks at 80 hours (within 12 months) or 480 hours in 26 consecutive weeks (within 6 months): 480 hours.

[9] Work requirement was raised from 225 hours (within 4 months) to 480 hours (within 6 or 12 months as explained in the note above).

The open and hidden measures of increasing member financing appear to have had significant effects upon fund membership only in Sweden as an effect of the radical 2007-reform. The Swedish government announced its decision to abolish the differentiated membership fees from 2013, but the damage had been done in terms of fund membership. In just two years, from 2006 to 2008, fund membership in Sweden decreased from 83% to 70% of the workforce (AK Samvirke 2012). The membership rate is a few percentage points higher in Denmark and about 75% in Finland.

An important element behind the traditionally high coverage of unemployment insurance has been a strong linkage in the Nordic Ghent countries between being a member of the trade union and its corresponding unemployment fund. This has been seen as the main explanation for very high trade union membership rates in Denmark, Finland and Sweden (Høgedahl 2014; Lind 2009; Rothstein 1992). However, fund membership and trade union membership is not the same thing, a fact which has become even more pronounced in all three countries. Trade union membership peaked in the mid-1990s at 80% in Denmark and Finland and 89% in Sweden, but had by 2009 declined to just below 70% in all three countries where it seems to have stabilized (OECD 2014b; Böckermann & Uusitalo 2006). In Norway, where unemployment insurance is compulsory, trade union density has been stable around 55%, still a wide margin above the 15-35% in most other Western countries. In Sweden and Finland, fund membership has to some extent been de-coupled from trade union membership when union-independent unemployment funds were set up in 1998 and 1992, respectively, while Denmark in 2002 passed legislation which allowed for cross-trade unemployment funds.

In all three countries, the development is a serious challenge to traditional, trade-based unions. Other factors are at play too, such as the changing composition of the labor force (fewer blue collar workers) and the steep membership decline among young age cohorts. The declining generosity of benefits (and the steep increase in member contributions in Sweden) is important too. However, the main explanation behind declining trade union membership seems to be the new funds independent of traditional trade unions (Lind 2009). For example, Böckermann & Uusitalo (2006) find that the new General Unemployment Fund from 1992 is the main explanation in Finland after controlling for the effect other factors, such as changing labor force composition, unemployment risk or cohort effects (lower membership among younger generations).

Social assistance: The residual nook of Nordic welfare

In terms of social rights for the unemployed, social assistance or minimum income protection for those not member of an unemployment fund is of course important, and has become

increasingly important as coverage of insurance has declined. Some retrenchment has also taken place here, however.

A national social assistance law as the heir to the old and extremely stigmatizing Poor Law was first enacted in Denmark in 1933. Finland, Norway and Sweden followed suit later with national legislation after World War II in 1956-1965. To cut short the historical account, the Nordic social assistance schemes all evolved from schemes with very high discretion for local municipal governments to define eligibility and benefit levels, a trait which continued even as they became inscribed in national legislation (Kuivalainen & Nelson 2012; Bahle et. al. 2011). Nordic social assistance was often characterized as more residual relative to other countries, which perhaps should be seen as a consequence of the very limited needs that needed to be covered (Lødemel 1997). As poverty was low and the coverage of unemployment insurance high, there simply was a smaller clientele for these benefits in the Nordic countries. As the universal welfare states had matured, social assistance was perhaps the last scheme to see steps towards a more rights-based approach. Finland was seen as a Nordic forerunner when it set national standards for benefit levels from 1989, while Denmark followed soon after and Sweden set a national standard in 1998 (Kuivalainen & Nelson 2012). Norway introduced guidelines in 2001, but substantial local discretion remains (Gubrium & Lødemel 2014; Kuivalainen & Nelson 2012). This means that Denmark has the most rights-based social assistance scheme since benefit levels are completely fixed at the national level, while Finland and Sweden have lower national base levels of social assistance supplemented by a range of variable and additional supplements depending on the costs of living of the individual recipient (Bahle et. al. 2011)

In this regard, it should be noted that Finland and Sweden have an extra benefit tier besides social assistance, where those who fulfill the work criteria for unemployment insurance, but are not fund members can receive a flat-rate benefit which is not means-tested. Sweden introduced this benefit tier in 1974 and Finland did the same in 1994 (Sjöberg 2011; Lilja & Savaja 2001). Before 1994, the Finnish scheme was a means-tested unemployment assistance scheme, enacted in 1960, but it became integrated within the unemployment insurance system in 1994 and means-test removed as a new means-tested assistance was adopted (Edling 2006; Clasen et. al. 2001). Both the Finnish and Swedish unemployment assistance schemes are referred to as ‘basic’ unemployment benefits.

While coverage of the Nordic social assistance schemes traditionally used to be quite low, mostly due to the well-developed ensemble of income protection in the Nordic countries, Nordic social assistance-benefits have usually been described as relatively generous in terms of benefit levels (Gough 2001). Today, that notion does not seem to find strong support when compared with benefit levels in other European countries (Figari et. al. 2013; Mechelen &

Marchal 2013; Bahle et. al. 2011). Benefit levels are difficult to compare across countries, particularly in the case of social assistance, because a range of supplementary and discretionary elements often play an important role for the total benefit package, but there is no doubt that social assistance has become less generous over time in the Nordic countries. Kuivalainen & Nelson (2012) utilize Nelson's own dataset on social assistance, and find that the equivalized disposaple income of recipients on social assistance compared the average wage earner dropped from 57% to 48% in Denmark, from 62% to 50% in Finland, and from 65% to 44% in Sweden, while Norwegian benefit levels have been stable around 45% in 1990-2008.

In Sweden, municipalities began excluding some of the items included in national guidelines on benefit calculations in the 1990s, and after the standardization of benefit levels in 1998 some items were removed from the range of supplementary benefits (ibid.) Finland lowered social assistance benefits in 1998, and a self-liability portion of housing costs were also adopted for housing benefits, but this measure was abolished again in 2006. In Denmark, the introduction of taxation for income benefits in 1994 was not fully compensated for single people and single parents, just as housing benefits also became less generous (ibid). Denmark from 2002 and onwards introduced measures like a ceiling for social assistance and a work requirement for couples on social assistance, where one partner could completely loose entitlements (Goul Andersen & Pedersen 2007). Another 2002-reform also contained a 'start assistance', which primarily affected immigrants and entailed significantly reduced benefits, but all of these measures from 2002 were abolished again in 2011 by the new Social Democratic-led government. Denmark has also introduced much lower social assistance for young recipients, which has gradually been extended to cover all able-bodied youths below 30 years.

Of great importance over the long run is of course the issue of indexation of benefits. The national benefit levels in Sweden and Finland are regulated only according to the price development, while the Danish indexation method is tied to the wage development (Kuivalainen & Nelson 2012). As regards the aforementioned unemployment assistance scheme in Sweden, today known as 'basic unemployment benefits', indexation was also frozen from the early 1990's and even lowered a few times (Clasen et. al. 2001). While the Danish indexation is more generous, it does have a hidden under-compensation, except in times of low economic growth as explained before on unemployment insurance. The method of indexation is the same for the two benefits in Denmark.

Health care: Decentralized universalism

Among the different models or configurations of health care, the Nordic countries are all characterized by universalism, where both financing, provision and regulation of health care is a

public responsibility (Böhm et. al. 2013; Wendt et. al. 2009). In terms of spending, the Nordic countries are among the countries with the highest levels of public spending and the highest share of public spending relative to total health expenditure (this has not applied to Finland since the 1990's, however) (OECD 2014c). In most recent years, 81-85% of health expenditure has been public (Finland 75%; EU 27-average 73%), and public spending amounted to 8-9% of GDP (Finland 6.6%; EU 27-average 6.5%). The greatest share of the non-public expenditure comes in the form of user-charges or fees for public health care or out-of-pocket payments for pharmaceuticals, especially in Finland, Norway and Sweden. Unlike the other countries, Denmark has no fees for treatment from general practitioners or hospitals, while total self-financing of dental care (except for limited reimbursements for the poorest) dominates in Denmark.

Universal and relatively generous health care is not at all exclusive to the Nordic countries. As an example, the British National Health Service (NHS) has long been known as a quintessential example of universal health care. Other country cases could also be named. What has been distinctly Nordic, however, is the degree to which local government (municipalities or counties) has been responsible for health care with some degree of state funding (Magnussen et. al. 2009; Byrkjeflot & Neby 2004). However, as we will see later, there have been some trends towards centralization in the new millennium.

Decentralization of public health care was a strong trait in the Nordic health systems even before they arrived at fully fledged universalism (Haave 2006). Historically, the Nordic countries were relatively hospital-centered in terms of hospital shares of total spending and health personnel (Haave 2006; Byrkjeflot & Neby 2004). In the three Scandinavian countries only a very small number of public hospitals were state owned (and managed by local-level government instead), while a relatively large share of the Finnish hospitals were state-owned until the 1950s (Vuorenkoski 2008). Responsibility for hospitals was later placed at the municipal level in Finland. The Hospital Act of 1990 brought all municipal hospitals under the management of 21 larger health care districts (Häkkinen 2005). They did not constitute a separate administrative county or regional-level body, but Finnish municipalities cooperated together in these hospital districts or 'hospital federations' to secure the necessary population base for specialized services. In Denmark, local responsibility for hospitals was established in a royal decree from 1806, long before the expansion of the hospital network to nearly every town. The hospital act of 1969 placed responsibility at the county level. After a period of state ownership, Sweden switched to the county level in the 1860s after the counties had been established in 1862. It was not until 1928 that hospital care became a legal obligation for the counties, however. Norway built a number of county-level hospitals after World War II, which

coexisted alongside the older municipal facilities, before transferring these to the county level in the 1960s.

Unlike most non-Nordic countries with universal health care such as Britain, the Nordic countries (except for Norway) did not arrive at universalism after switching from a primarily social insurance-based model. Social insurance played only a minor role for specialized or inpatient treatment (Haave 2006). Norway introduced compulsory sickness insurance in 1909 (coverage was not universal or population-wide until 1957), which provided both medical and cash benefits. The other early Nordic schemes primarily aimed at providing income support and a few medical benefits in kind. Here, inpatient treatment at hospitals was primarily funded through public budgets, and social insurance only played a minor role. Denmark and Sweden introduced voluntary, state-supported sickness insurance-acts in the 1890s.

While insurance had played only a minor role in hospital care (except for Norway), it did, however, play a large role in terms of primary care, especially in Denmark (Martinussen & Magnussen 2009). Besides Norway, the Danish development is closest to resembling a switch from a social insurance-model to universal, national health care. However, since insurance was heavily regulated and healthcare provision was heavily hospital-centered in Denmark as in the other Nordic countries, financing and provision has been primarily public since the late 19th century (Wendt et. al. 2009).

In Denmark, sickness insurance funds sprang up first from craftsmen's guilds in the second half of the 1800s, which later spread to other group of laborers (Vallgårda & Krasnik 2010, 1999). The formation of sickness funds is also one reason why Denmark relatively early had such a well-developed coverage of local physicians or doctors compared to the other Nordic countries (Vallgårda & Krasnik 1999). Denmark began publicly subsidizing sickness funds in 1892, and the social reform of 1933 in also made membership compulsory (in order to be eligible for old-age support) for people below a certain income level (Vallgårda & Krasnik 2010). In Denmark, Coverage of sickness insurance was extended to all wage earners in 1960, and the system which had hitherto aimed at 'excluding the rich' from primary care, having been in place since state-subsidization began in 1982, was abolished (Petersen 2012). From 1973, the sickness funds were abolished, and the counties assumed responsibility for financing, regulation and providing both primary and secondary health care. The sickness fund 'Danmark' survived, however, and continues to ensure members against medical expenses not covered by public health care (membership stood at more than 2.2. million in 2012), such as pharmaceuticals or dental care.

In Sweden, the most important final step towards universalization beyond compulsory sickness insurance in 1955 was the so-called "Seven Crown Reform" of 1970. Not only did it firmly place all kinds of specialized care (it had only been hospitals up to that point) at the county level, but it made health care much more accessible to low-income groups with the state reimbursing the expenses of counties (Byrkjeflot & Neby 2004).

Norway as noted earlier made its compulsory insurance fully universal in 1957, but the final step towards the modern, universal health system came in 1967 when the country set up its National Insurance Scheme in 1967 (Johnsen 2006; Kuhnle 1987). From 1971, health insurance was also integrated within the scheme, and sickness insurance was included in general taxation, where it became visible as a 'health tax' (Haave 2006).

Finland was the last European country to legislate compulsory sickness insurance in 1963. In the Finnish case, the universal-coverage act of 1963 did not eliminate inequalities in access to health care since so much depended on the resources of local municipalities. The state in the 1970s assumed a much stronger role in terms of financing and initiated the construction of new facilities (Kangas & Saloniemi 2013; Vuorenkoski 2008). The Primary Health Care act of 1972 laid out the foundations for the present-day system of municipal health centres.

Reinforcing the supplementary role of private health care

The universalization of health care never completely crowded out the private sector. In primary care, general practitioners (GP's) as gatekeepers to specialized treatment are often self-employed, but publicly funded. In Denmark, a legacy from the sickness funds and their well-developed network of primary care mentioned above has been that GPs remained outside formal public ownership after the 1973-reform, even if their services became completely tax-financed.

In Sweden, by contrast, the aforementioned "Seven Crown Reform" of 1970 gave further push to the trend of physicians becoming salaried employees of local counties (Byrkjeflot & Neby 2004). From 1994, however, the Family Doctor Act and the Act on Freedom to Establish Private Practice enabled general practitioners to become independent or more specifically revoked the counties' regulations on the number of private practitioners and also gave citizens freedom to freely choose their own GPs (Martinussen & Magnussen 2009). Even though the reforms were quickly withdrawn when the Social Democrats re-entered government office, many counties had already implemented them. A new Freedom of Choice-act entered into force in 2010, which obliged counties to allow for citizens to choose between primary care-providers, with reimbursements following the citizen regardless of public or private ownership (Anell et. al.

2012; Nordgren & Ahgren 2011; Häkkinen & Jonsson 2009). By 2011, about 40% of all doctor visits were provided by private GPs.

Norway was inspired by the Danish organization of GPs when it passed a reform of primary health care in 2001 (Hagen & Vrangbæk 2009; Martinussen & Magnussen 2009). Aiming to reduce turnover among GPs and to induce more stability in the GP-relationship, the reform meant that every citizen became listed with a specific GP as in Denmark and about 90% of GPs in the following years chose to become self-employed.

Finland generally retained its system of publicly owned health centers in primary care at the municipal level, but some municipalities have contracted out the management of health centres to private providers (Saltman & Vrangbæk 2009). Private leasing of physicians to public health centres has also been a new trend in Finland (Martinussen & Magnussen 2009). While contracting out has not been prevalent, the private sector has long had a strong supplementary role in Finland, especially in primary care. In terms of both expenditure and employment, the non-public sector has grown much faster than the public since the 1990's (we will return to this below).

In terms of hospital care, the role of private providers remains very modest. In all the Scandinavian countries, around 90% or more of patients receive care at public hospitals (Martinussen & Magnussen 2009). The role of private providers has certainly grown. Much of it is a result of increasing patients rights' legislation coupled with free choice between public and private providers (Ministry of Social Affairs and Health 2013; Anell et. al. 2012; Tynkkynen 2009; Winblad & Ringaard 2009). While all the Nordic countries have extended patients' rights and introduced waiting time guarantees, general free choice for patients between public and private hospital care at the national level has only been introduced in Denmark and Norway, while Sweden has introduced free choice within counties, adapted and implemented by counties themselves (Anell et. al. 2012; Hem et. al. 2011). Free choice of general practicioners in primary care has been expanded and legislated at the country-level in all three Scandinavian countries. Finland has also introduced choice at the national level for all forms of care, but only for health care provided by municipalities, which may or may not be private. Free choice between public and private only applies to statutory occupational health care.

In Denmark, the use of private hospitals has been curtailed somewhat by means of fewer referrals for private treatment and lower public subsidies. Therefore, while their share of patients is higher, private treatment with public funding had declined to only 1.25% of expenditure in 2012 (CEPOS 2013). The role of private hospitals in Norway increased with a 2002-reform, which we will return to below. The reform caused the use of private treatment to

triple in 2002-2005 (from a very low point of departure), but this was later curtailed somewhat by the new centre-left government (Saltman & Vrangbæk 2009). In Finland, private care is reimbursed by the national Social Insurance Institution (formally 30%, but usually somewhat less) (Ministry of Social Affairs and Health 2013; Häkkinen & Jonsson 2009; Saltman & Vrangbæk 2009; Wahlbeck et. al. 2008). However, partly spurred by occupational insurance (where reimbursements are higher, which we will return to below) and municipal contracting out, private providers have come to play a more significant role in hospital care. While private treatment has expanded by means of insurance, contracts or waiting list guarantees in Denmark, Finland and Norway, the issue has been more politicized in Sweden (Berglund & Esser 2013; Häkkinen & Jonsson 2009). Two local counties (Stockholm and Scania) run by right-wing local governments directly sold one public emergency hospital and several more were prepared for privatization in the late 1990s, but the Social Democrat government enacted a ban on further contracting out of hospitals from 2001. The centre-right government coalition from 2006 later overturned some restrictions in this regard.

Private health insurance has as hinted just above come to play a larger role in all the Nordic countries, but can so far be regarded as a rather modest and supplementary layer on top of the universal health systems. The expansion of private health insurance coverage has been most prominent by far in Denmark (Berge & Hyggen 2010; Martinussen & Magnussen 2009). One important push for this happened in 2002, when the liberal-conservative government introduced tax subsidies for private health insurance provided by employers under the condition that coverage included all employees and not just specific employee-groups (Beland et. al. 2014; Kjellberg et. al. 2010). The new centre-left government abandoned tax subsidies again in 2011, but coverage of private insurance has continued to expand. By 2012, just below 2 million Danes were covered by private health insurance in some form (Forsikring & Pension 2014). While this presents an extreme development in terms of coverage, it does not mean that one-third of the population (almost exclusively people in employment) has quit public health care. The revenues of the small private sector is still overwhelmingly coming from publicly funded patients referred because of waiting list guarantees, free choice, etc, and insurance-covered or self-paying patients constitute a small minority (Kjellberg et. al. 2010). No doubt, an important factor behind the Danish development is the way in which supplementary insurance has become a normal part of the employment package for job holders just as supplementary unemployment insurance now is in Sweden as noted earlier. The difference is that the Swedish private unemployment insurance has become a part of collective agreements, while it has taken place at the firm-level in Denmark.

In the other Scandinavian countries, the development is far less pronounced. In Norway, 333.000 Norwegians, or a little less than 7% of the population, had some form of private

insurance in 2012, while the figures for Sweden were 464.000 or just below 5% of the population in 2011 (SKL 2012; Manifest Analyse 2012). As in Denmark, the vast majority of these are covered through their employer, so coverage among the employed is much higher. Unlike Denmark, however, the development is not spurred by legislation or tax deductions. In Norway, insurance drawn up by employers were tax deductible from 2003, but this was repealed again by the new Social Democrat government in 2006 (Berge & Hyggen 2010).

Finland is a Nordic peculiarity in this regard since occupational health insurance is statutory (Ministry of Social Affairs and Health 2013; Wahlbeck et. al. 2008). Employers in Finland are required to offer free occupational healthcare for their employees. Coverage is around 85-90% of employees since not all small enterprises are enrolled while participation is voluntary for farmers and self-employed. Occupational health care is subsidized by the aforementioned Social Insurance Institution by 50-60 %, while there is a corporate tax deduction for the remaining 45% (Saltman & Vrangbæk 2009; Wahlbeck et. al. 2008). In terms of provision, employers can choose between either setting up their own, buying from other employers, purchasing from municipal health centres or from private providers. Only a small minority of occupational insurance is provided by municipal health centres, and the increasing utilization of occupational health insurance in primary care has fuelled the growth in non-public health care delivery mentioned above (Wahlbeck et. al. 2008). The most important reasons for this development is shorter waiting times in occupational health care and access to a broader spectrum of treatment. This has led to significant inequalities in health care utilization in Finland. In 2000, Finland was found be among the OECD-countries with the greatest pro-rich inequality in doctor visits along with Portugal and the United States (Kangas & Saloniemi 2013; Wahlbeck et. al. 2008). The Occupational Health Care Act came into effect in 1979, but its effect has been more keenly felt in more recent decades as the perception of insufficient staffing or too long waiting times in municipal health care became more widespread. In that sense, the Finnish development seems so far to have had more significant consequences regarding the crowding-in of non-public health care than has the recent Danish expansion of private health insurance for employees. In addition, private health insurance has also bloomed in Finland. In 2012, around 1 million Finns (or 20% of the population) have private insurance, with about half of them being drawn up by parents who wish to cover their children (Kangas & Saloniemi 2013). All told, the private sector accounted for 25% of expenditures and 20% of personnel in health care provision in 2009 (Arajärvi & Väyrynen 2011). This substantiates how health care in Finland is significantly less 'public' than in the other Nordic countries, as mentioned in the beginning.

Introducing market mechanisms in public health care

The organization and regulation of public health care has also been changed significantly. As mentioned in the beginning, a very distinct Nordic trait has been the decentralized provision of health care. Particularly Norway and Denmark adopted reforms in the new millennium which raises the question of whether the decentralized Nordic path has been challenged or perhaps even abandoned (Byrkjeflot & Neby 2004).

A 2002-reform in Norway transferred hospital and other forms of specialist care from 19 counties to the state, with health care provision being organized by five (later four) regional health enterprises under the Ministry of Health (Hippe & Berge 2013; Martinussen & Magnussen 2009; Byrkjeflot & Neby 2004). With the main idea being that hospitals should act more like private enterprises, they were restructured into semi-independent public firms.

Similarly, Denmark from 2007 implemented a structural reform which reduced the number of local authorities from 14 counties to 5 regions and from 275 municipalities to 98 (Martinussen & Magnussen 2009). The new and larger regions retained their responsibility for health care, but the most important change in the reform was that the authority to set independent tax rates was removed from the new regions. Instead, financing has largely become a matter for the central government, with only a small share of reimbursements coming from municipalities. Fiscal centralization also characterized the Norwegian reform, but while counties already were very limited in setting tax rates before the 2002-reform, the Norwegian reform further replaced unconditional block grants from the government with conditional and activity-based funding (Rehnberg et. al. 2009; Häkkinen 2005).

Similar attempts at centralization have been attempted in both Sweden and Finland, however. In these two countries, it was until recently more of a coordinated bottom-up process rather than the big-bang, top-down reforms of Denmark and Norway. Sweden tried to initiate a process of voluntary mergers over several years after a structural reform commission handed in its report in 2007 (Martinussen & Magnussen 2009). The process collapsed in 2012, however, as no counties managed to present any final mergers to the government (Karlsson & Bretzer 2012). A similar process of mergers has been more successful in Finland, but here it has taken place at the municipal level (where health care responsibility has hitherto been placed). The Finnish government began subsidizing municipal mergers already in 2002, but the central government adopted a skeleton law in 2007 to increase reform impetus, which aimed for a minimum municipal size of 20.000 inhabitants (Blöchliger & Vammalle 2012; Häkkinen & Jonsson 2009). Financial incentives for mergers ended in 2013, but the process is on-going. Between 2001 and 2014, the number of municipalities was reduced from 452 to 320

(Population Register Center of Finland 2014; Blöchliger & Vammalle 2012). Finally, by late 2014 a new health care reform was agreed upon by the government coalition, which when implemented will place responsibility for all forms of health care in new regional units (the 'SOTE-reform')

Sweden has led the charge on other aspects of public health care reform, however. Many of these have had the aim of introducing market-mechanisms internally in the public sector, often described under the heading of New Public Management (NPM). Inspired by similar British efforts, a number of Swedish counties in the beginning of the 1990s introduced the purchaser-provider model (PPM), where political steering and professional provision of health care is separated to a higher degree (hence the split between purchasers and providers) (Martinussen & Magnussen 2009; Haave 2006). The aim is to promote competition between providers. This of course demanded increased contract-based relationships and increased use of activity-based funding between the separate bodies in terms of financial allocation. Half of the counties had adopted the model by 1994, but optimism changed to skepticism later (Martinussen & Magnussen 2009; Byrkjeflot & Neby 2004). PPM and activity-based funding therefore increasingly became accompanied by price or volume ceilings as well as quality standards. The use of PPM did not expand the role of private provision very much.

Norway followed suit with PPM around the same time as Sweden, but the extent was less significant and the process slower. By 2004, only 30% of municipalities had introduced PPM-models in primary care (Martinussen & Magnussen 2009). The 2002-reform in essence introduced some form of PPM-split in hospital care when it shifted hospitals from the county to the state-level, but with hospitals as independent 'health enterprises'. Activity based funding, however, was implemented nationally from 1997 for hospital services based on national standards for fees and reimbursements (ibid.). Hence the much lower share of unconditional block grants in Norway mentioned above.

Denmark did not introduce the formal split of the PPM-model, but the use of internal, contract-based financial allocation became widespread in the new millennium. Like Norway, it happened as a push from above, but in the Danish case it was through agreements with the central government which defined how large a share of funding should be activity-based. Therefore, Sweden may have ushered in the trend of activity-based funding, but it became much more utilized in both Denmark and Norway, while the trend grinded to a halt in Sweden (Rehnberg et. al. 2009). In Finland, the use of PPM spread to a significant minority of municipalities later in the new millennium even though PPM was legalized already in 1993 (Tynkkynen 2009). However, Finland in many ways already had strong traits of PPM with its organization of

municipalities as purchasers of services together in hospital districts (Martinussen & Magnussen 2009).

Conclusion

The Nordic 'model' or welfare regime has perhaps always been easiest to identify on a range of socio-economic outcomes such as relatively low inequality, low poverty rates, low material deprivation and high social cohesion, both in terms of participation and social trust. When we focus solely on the welfare state, the picture is decidedly more mixed. Sometimes, the Nordic model has been described as a model with five exceptions (including Iceland), or as an ideal in the minds Nordic people (Petersen 2011; Cox 2004). However, some commonalities regarding policy institutions are identifiable, many of which have been mentioned above. These countries were much closer than elsewhere to archetypal social policy universalism with Finland as the borderline case or universal/conservative hybrid. Nordic universalism has been no frozen landscape, however, and here we have tracked the most important changes in the policy fields of pensions, health care and unemployment protection.

Health care universalism endures, where the private sector to a large extent can be said to have been consolidated as a supplement. The still limited private sector has primarily grown as an institutionalized element within universal, tax-financed welfare, and less so as an isolated playground for private health insurance. Once again, Finland is the exception. Private insurance has increased dramatically in Denmark, but so far it has not changed the role of the public sector significantly, even if it may do so in the future.

In the field of pensions, reforms have been transformative and to a large extent abandoned universalism in principle. Universal pensions have given way to earnings-related public pensions or labor market pensions. In Denmark, the public people's pension still has an element of ideal-typical universalism. However, minimum benefit levels for those reliant on public basic pensions are still relatively high in all the countries. Denmark and Finland has not incorporated earnings-related pensions into the public pension system as in Norway and Sweden, but coverage of private labor market pensions is quasi-universal if sectorally divided.

Clear-cut retrenchment is visible within unemployment protection. Benefit levels in unemployment insurance and social assistance has declined, most significantly in Sweden. The coverage of unemployment benefits was already relatively moderate in Finland, while it has declined in Sweden due to reforms in the new millennium. Denmark has continuously cut down on benefit duration and restricted access to benefits, but it has not had a major impact on coverage until recently.

The three policy fields selected here are illustrative examples of the main trends uncovered in recent comparative welfare state research. The Nordic countries continue to be most distinct in welfare services and especially care policies, even if non-Nordic Europe to some extent has converged towards the Nordic countries, especially in family policies. As regards income transfers for the working-age population we see some of the most significant changes and real steps towards de-universalization. Here, the Nordic welfare states have been subject to some of the same trends that can be identified in most of Europe.

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